Medical Examiner Department
Public Interment Program

DATE:_____/_____/_____
Month/Day/Year

Financial Disclosure Statement

Name of Decedent: _____

I do hereby declare that as the legal next of kin of the above referenced decedent, I am unable to assume financial responsibility for funeral arrangements. I understand that Miami-Dade County reserves the right to fully investigate all claims of indigency and will diligently seek reimbursement of all funds provided for the final disposition of the decedent.

_____
Print Name

_____ _____
Signature Relationship to Decedent

Address: _____

City/State/Zip: _____

Telephone: (Day) _____

(Eve) _____

For PIP Office Use
PIP Case Number: